

196 Short Stays -- Generally, patients discharged from the hospitals in less than 24 hours are classified and billed as "outpatient." An exception to this policy involves maternity care. DRGs 370-375 and 388-391 cover deliveries and babies. These services are paid as inpatient services under the DRG system.

INPATIENT HOSPITAL
Section 200 Other Payments

210 Small Volume Utah and Out-of-State Hospitals -- Except as provided in Section 190, payment will be made under the same DRG methodology as in-state urban hospitals.

240 Sub-acute Care and Swing-beds -- This policy pertains to patients that do not require acute hospital care.

- When sub-acute care patients receive medically necessary services in an inpatient hospital setting, payment is made at the swing-bed rate. Because sub-acute patients require a lower level of care, the rate is lower than the rate paid for acute hospital services. The sub-acute rate is calculated using the criteria specified in 42 CFR 447.280(a)(1).
- When nursing home beds are not immediately available in the community, patients may receive skilled or intermediate nursing care in a bed of a qualified hospital. Rural hospitals typically qualify for the swing-bed program. Payment is made at the swing-bed rate using the criteria specified in 42 CFR 447.280(a)(1). Patients are transferred to licensed nursing home beds in certified facilities when such beds are available in the community.
- Services provided in hospitals licensed as chronic disease or rehabilitation will be paid the nursing facility intensive skilled rate defined in Section 1000 of Attachment 4.19-D of the State Plan, as modified by this Section. Rehabilitation days of care require prior approval to qualify for payment. Intensive skilled rates are negotiated for individual patients. In determining the intensive skilled rates for hospital rehabilitation units, therapy costs are allowed to be included with nursing costs referenced in therapy costs are allowed to be included with nursing costs referenced in Attachment 4.19-D, Section 1000. In addition, the intensive skilled payment is limited to the amount Medicare would pay for the same services at the same facility.

241 Insignificant Billing Variances -- When the Medicaid payment is determined using the billed usual and customary charges (i.e., rural hospitals), insignificant billing errors may be processed. To expedite payment and to reduce administrative effort, Medicaid pays the lesser of the detailed charges or the total charges, if the difference is ten dollars or less.

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250 Payment for Emergency Days -- Emergency days for inpatient psychiatric services cover the time between admission and the first service date authorized by the Medicaid prior authorization staff. Emergency days under the DRG system will be paid a per diem for each approved day. As with transfer patients, the DRG per diem will be calculated by dividing the DRG payment by the arithmetic mean length of stay.

251 Third-party Payment -- When insurance or other third-party payors have responsibility for payment, Medicaid is the payor of last resort. The amount paid by Medicaid is limited to the patient's liability. Further, Medicaid payment for specified Medicare crossover claims will be the lower of: (1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors, or (2) the Medicare co-insurance and deductibles.

252 Interim Payments -- There are two types of interim payments for DRG hospitals. First, hospital stays in excess of 90 days may be billed under the DRG system prior to discharge with prior approval. The interim bill is paid at 60% of the allowed charge. Second, an interim payment may be granted when the lag time between the date of service and the date of payment for a specific hospital is above the "mean" processing time for all DRG hospitals. In addition, the hospital requesting the interim payment must be able to document a cash flow problem that could impair patient care. The amount of the interim payment is based on the cash flow needs of the hospital not to exceed the Medicaid interim payment limit. The interim payment limit is calculated by multiplying the number of days above the "mean" processing time by the average daily Medicaid payment.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals

409 INTRODUCTION -- This section establishes criteria for identifying and paying disproportionate share hospitals (DSH). For the purpose of paying disproportionate share hospitals, there are five types of hospitals: First, private hospitals licensed as general acute hospitals located in urban counties; Second, general acute hospitals located in rural counties; Third, the State Psychiatric Hospital; Fourth, the State Teaching Hospital; and Fifth, Childrens' Hospitals.

410 DEFINITIONS- For purposes of this section, the following definitions apply:

- A. Medicaid Inpatient Utilization Rate (MIUR) is the percentage derived by dividing Medicaid hospital Inpatient days (including Medicaid managed care inpatient days) by total inpatient days.
- B. Low Income Utilization Rate (LIUR) is the percentage derived by dividing total Medicaid revenues (including Medicaid managed care revenues) plus UMAP revenues by total revenues and adding that percentage to the percentage derived from dividing total charges for charity care by total charges.
- C. Indigent patient days is the total of Medicaid patient days (including managed care days) plus UMAP patient days and other documented charity care days.
- D. UMAP is the Utah Medical Assistance plan operated for low income (indigent) recipients not eligible for Medicaid.

411 OBSTETRICAL SERVICES REQUIREMENT -- Hospitals offering non-emergency obstetrical services must have at least two obstetricians providing such services. For rural hospitals, an "obstetrician" is defined to include any physician with staff privileges who performs non-emergency obstetrical services at the hospital. This requirement does not apply to children's hospitals nor to hospitals which did not offer non-emergency obstetrical services as of December 22, 1987.

412 MINIMUM UTILIZATION RATE — All DSH hospitals must maintain a minimum of 1% Medicaid patient utilization rate.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

413 HOSPITALS DEEMED DISPROPORTIONATE SHARE -- A hospital is deemed a disproportionate share provider if, in addition to meeting the obstetrical (Section 411) and the minimum utilization rate requirements (Section 412), it meets at least one of the following five conditions:

- A. The hospital's MIUR is at least one standard deviation above the mean MIUR. The disproportionate share computed percentage is based on the number of percentage points that an individual hospital indigent patient days exceeds the statewide average plus one standard deviation.
- B. The hospital's LIUR rate exceeds 25 percent.
- C. The hospital's MIUR exceeds 14 percent.
- D. The hospital's UMAP participation is at least 10 percent of total hospital UMAP patient care charges.
- E. Hospitals located in rural counties qualify because they are sole community hospitals. A sole community hospital is defined as a hospital that is located more than 29 miles from another hospital.

414 PAYMENT ADJUSTMENT FOR GENERAL ACUTE URBAN (excluding State Teaching Hospital and Childrens' Hospital) - - General Acute Urban Hospitals (Paid by DRGs) and meeting the qualifying DSH criteria are paid a DSH amount on each inpatient claim. The DSH Factor is derived by dividing the indigent inpatient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH Factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor.

415 PAYMENT ADJUSTMENT FOR GENERAL ACUTE RURAL -- General Acute Rural Hospitals are paid a DSH payment amount on each inpatient claim. The hospital must qualify based on the criteria shown in section 413 above. The DSH factor is derived by dividing the indigent patient days by the total general acute days for each hospital and multiplying by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limits. The resulting percentage (DSH factor) is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid payment times the DSH factor.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

416 PAYMENT ADJUSTMENT FOR STATE PSYCHIATRIC HOSPITAL -- The State Psychiatric Hospital is reimbursed on a retrospective annual cost settlement basis. Its DSH payment is calculated on the proportion of indigent patient days to total inpatient days. The indigent proportion is multiplied by a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed Federal DSH limits. The result is the DSH factor which in turn is applied to the cost settlement amount. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The DSH is paid as an interim payment during the year, with a final computation being completed with the settlement of the annual cost report.

416A CAPITALIZATION OF ASSETS -- In establishing allowable cost, the Utah State Hospital is required to capitalize only those assets costing more than \$5,000.

417 PAYMENT ADJUSTMENT FOR STATE TEACHING HOSPITAL -- The hospital's DSH factor is the ratio of Indigent patient days to total patient days times a "ceiling factor". The "ceiling factor" is an artificial factor assigned to ensure that DSH payments do not exceed federal DSH limit amounts. The resulting DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment amount will necessarily be adjusted to reflect federal DSH limits.

418 PAYMENT ADJUSTMENT FOR CHILDRENS' HOSPITAL -- The Childrens' hospital DSH factor will be computed as a separate category from other general acute hospitals. The DSH payment will necessarily be adjusted to reflect Federal DSH limit amounts. The hospital's DSH factor is the ratio of Indigent inpatient days to total inpatient days times a "ceiling factor". This DSH factor is rounded to the nearest whole percent. The DSH payment amount is the product of the Medicaid DRG payment times the DSH factor. The DSH payment for this category of hospitals will have a base year of 1999, i.e., DSH payments will not be less than the amount paid under a previous hospital category (General Acute Urban), subject to Federal DSH limit adjustment.

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INPATIENT HOSPITAL
Section 400 Adjustment for Disproportionate Share Hospitals (Continued)

421 METHOD AND TIMING OF DSH PAYMENTS -- Each claim for payment to qualified providers includes a percentage add-on at the level specified for that facility. Each quarter the total amount of DSH to all qualified facilities is calculated. The amount, along with any preceding quarters for the current fiscal year, is used to predict the total amount that will be paid. If this exceeds the current DSH allotment, the payment level will be adjusted in order to correct for any potential overpayment. This adjustment will be applied to all hospitals proportionally, except for Childrens' hospital which will not be adjusted below the base year (see section 418).

INPATIENT HOSPITAL
Section 500 Inpatient Rehabilitation Services

501 General -- Because of the wide variation in the length of stay for rehabilitation services under DRG 462, there is a need to refine the DRG criteria. Rehabilitative services under DRG 462 are subdivided into five groups. Each group has an established average length of stay and a base payment calculated in accordance with Section 122 of Attachment 4.19-A. Payments are made for outliers above the designated threshold consistent with other DRG payments.

510 Designated Groups -- Rehabilitation is subdivided into the following groups: (1) Spinal -- Para; (2) Spinal -- Quad; (3) Head; (4) Stroke; and (5) Other. "Spinal -- Para" includes patients with paraplegia who require an initial intensive inpatient rehabilitation program. "Spinal -- Quad" includes patients with quadriplegia who require an initial intensive inpatient rehabilitation program. "Head" includes patients with head trauma and with documented neurological deficits who require an initial intensive inpatient rehabilitation program. "Stroke" includes patients

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needing an initial intensive inpatient program because of disability due to a neurological deficit secondary to a recent cerebrovascular disease. "Other condition" includes patients with a neurological/neuromuscular disease or other disorder requiring intensive inpatient rehabilitation. The State Medicaid Agency requires prior approval of all classifications.

INPATIENT HOSPITAL

Section 600 Inpatient Medicaid DRG Refinement

601 General – Due to the unique nature of Medicaid population, selected Medicare DRG have been refined and expanded into additional DRGs.

610 Neonate DRGs – Discharges under DRGs 385, 386, and 387 for neonate DRGs are broken out as follows:

DRG	Description
850	DRG 385 - NEONATE XFERED OR EXPIRED (Died <=1 day)
851	DRG 385 - NEONATE XFERED OR EXPIRED (Died >= 2 days)
852	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred <= 10 days)
853	DRG 385 - NEONATE XFERED OR EXPIRED (Transferred >= 11 days)
860	DRG 386 - NEONATE EXTREM IMMATUR/RDS < 500 grams
861	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 500 to 749 grams
862	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 750 to 999 grams
863	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1000 to 1199 grams
864	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1250 to 1499 grams
865	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1500 to 1749 grams
866	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 1750 to 1999 grams
867	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2000 to 2499 grams
868	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2500 grams and over (with ICD9 Proc code = 9672)
869	DRG 386 - NEONATE EXTREM IMMATUR/RDS - 2500 grams and over (w/o ICD9 Proc code = 9672)
880	DRG 387 - PREMATURE W/MAJ PROBLEMS - < 500 grams
881	DRG 387 - PREMATURE W/MAJ PROBLEMS - 500 to 749 grams
882	DRG 387 - PREMATURE W/MAJ PROBLEMS - 750 to 999 grams
883	DRG 387 - PREMATURE W/MAJ PROBLEMS - 1000 to 1199 grams
884	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1250 to 1499 grams
885	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1500 to 1749 grams
886	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 1750 to 1999 grams
887	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 2000 to 2499 grams
888	DRG 387 - PREMATURE W/ MAJ PROBLEMS - 2500 grams and over

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The fifth digit of ICD9-9-CM diagnosis codes 764 to 765 identifies birth weight. If no birth weight is provided in the medical record, the DRG with the highest birth weight will be paid.

620 – Psychiatric DRGs – Psychiatric DRGs are as follows:

DRG	Description
900	SCHIZOPHRENIA (UNDER AGE 13)
901	SCHIZOPHRENIA (OVER AGE 13)
902	PSYCHOSIS (UNDER AGE 13)
903	PSYCHOSIS (OVER AGE 13)
904	NEUROTIC DEPRESSION (UNDER AGE 13)
905	NEUROTIC DEPRESSION (OVER AGE 13)
906	ANXIETY (UNDER AGE 13)
907	ANXIETY (OVER AGE 13)
908	MISC. NEUROSIS (UNDER AGE 13)
909	MISC. NEUROSIS (OVER AGE 13)
910	PSYCHOPHYSIOLOGIC (UNDER AGE 13)
911	PSYCHOPHYSIOLOGIC (OVER AGE 13)
912	ADJUST. REACTIONS (UNDER AGE 13)
913	ADJUST. REACTIONS (OVER AGE 13)
914	MISC. DISORDERS (UNDER AGE 13)
915	MISC. DISORDERS (OVER AGE 13)

630 - Rehab DRGs – Rehabilitation DRGs are as follows:

DRG	Description
800	REHAB - SPINAL/PARA
801	REHAB - SPINAL/QUAD
802	REHAB - HEAD
803	REHAB - STROKE
804	REHAB - OTHER

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